STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29C0001040	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUAIL SURGICAL & PAIN MGMT CTR	6630 S. MCCARRAN BLVD BLDG C RENO, NV 89509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 000	INITIAL COMMENTS The following Statement of Deficiencies was generated as the result of a full Medicare survey conducted at your facility on 4/16/08 and 4/17/08. The full Medicare survey was directed by the Centers for Medicare and Medicaid Services as the result of Complaint # NV00017895. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The facility was in compliance with all Conditions for Coverage. The following standard level deficiencies were identified:	Q 000		
Q 014	416.44(a)(3) ELEMENT of STANDARD PHYSICAL ENVIRONMENT The ambulatory surgical center must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities. This ELEMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to secure used needles and syringes. Findings Include: On 4/16/08, at 9:00 AM observations were made of the pre-operative area. A large sharps container was observed in the area's private pre-operative room. The container's opening was	Q 014		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Q 014	Continued From page 1 large enough for a person to put their hand through and remove used needles and syringes from the container. The contents of the container would be easily accessible to a patient in the private room. In addition, there were five pre-operative patient stalls with privacy curtains between each. Each stall had an unsecured, large sharps container similar to the one in the private room. Observations were made that patients were left alone at times in the stalls and out of direct visual contact of staff. The contents of the sharps container would be easily accessible to a patient in one of the stalls. On 4/16/08 at 9:08 AM, the director of nurse's stated that patients in the private room are left alone at times.	Q 014		
Q 030	416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. This STANDARD is not met as evidenced by: Based on observation and interview it was determined that the facility failed to prepare and administer medications according to acceptable standards of practice. Findings Include: Patient #1: On 4/16/08, Patient #1's surgical procedure was observed from the beginning of the case (approximately 9:20 am) to the end of the case. During the surgical procedure Physician #1 opened a glass ampule of medication and withdrew the medication with a regular, non-filtered needle. He administered the medication, which had not been filtered with a	Q 030		

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Q 030	Continued From page 2 filter needle prior to administration, to the patient. On 4/17/08, Physician #1 stated that he was not aware of the need to use filter needles to withdraw medications from glass ampules prior to administering the medication to a patient. On 4/17/08, at 10:50 AM, a telephone interview was conducted with the facility's pharmacist. He stated that the standard of practice was that a filter needle be used to withdraw medications from all glass ampules. On 4/17/08, the director of nursing stated that the facility did have medications in glass ampules and that there were no filter needles available to the operating room. She did not know if the epidural packages used for pain management patients contained filter needles. On 4/16/08, at 11:45 AM, observations were made of the fluid warmer in the recovery area. On the bottom shelf of the warmer there were 1000 milliliters (ml) sized intravenous (IV) fluid bags for IV use on patients. The recovery room charge nurse stated these fluids were rotated daily. On the top shelf of the warmer there were smaller sized IV fluid bags. The charge nurse stated these fluids were not used as frequently. An observation was made of an IV fluid bag with its outer package intact. The inside of the package with the IV bag in it was completely puffed up with air. A second bag, on the top shelf, was also observed to be partially puffed up with air. The charge nurse confirmed there was no method, such as dates on the outer packaging of the bags, to indicate how long they had been in the warmer.	Q 030		

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Q 030	Continued From page 3 On 4/16/08, at 3:10 PM, the director of nursing (DON) was interviewed. She stated that the manufacturer recommended that IV fluids be stored in the warmer for no longer than 14 days. It was confirmed with the DON that there was no mechanism to know how long the IV fluids on the top shelf of the warmer had been in there. She did mention that the fluids on the bottom shelf were rotated through daily.	Q 030		